KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
HEALTH OCCUPATIONS CREDENTIALING

APPLICATION FOR APPROVAL OF TRAINING COURSE

Course Type : _____ Course Delivery Method: _____

Students must pass an 8th grade reading level and comprehension test before enrolling in those courses marked with asterisk (**).

NOTE: Please consult appropriate Instructor manual for guidelines on filling out this application.

This application MUST be received by this office THREE WEEKS (21 days) prior to the beginning date of the course. If not, the application will be returned so that the dates of the course can be adjusted to meet the three week requirement. If a request for waiver is included, both the application and the waiver MUST be received by this office FOUR WEEKS (28 days) prior to the course start date.

Date Application Submitted _____ Date received by HOC _____

Course Begins _____ Course Ends _____

Primary Instructor Name _____ Instructor's ID# _____

Current Address: _____
Street City State Zip

Current Phone Number: _____ E-Mail address: _____

KS RN License # _____ KS RN Licensure Expiration Date _____

Sponsoring Facility/School _____ KS Facility/School ID# _____

Coordinator Name _____ Phone # _____

Address _____
Street and/or PO Box City State Zip

Clinical Site _____ KS Facility ID# _____

Address _____
Street and/or PO Box City State Zip

Classroom Site _____ _____
Address City

Examination Site Preference: _____

Course Training Includes:

	PART 1 (If applicable)	PART 2 (If applicable)	TOTAL HOURS
CLASS HOURS			
LAB/CLINICAL HOURS			
TOTAL HOURS			

Please adapt the grid to the type of course given. For courses which do not have two parts, use the ëTOTAL HOURSÈ col umn to ente the number of hours. Be prepared to present course schedule (topics, times and dates) on request.

DEPARTMENT USE

Course #_____ Approval Date: _____ Disapproval Date: _____

Reviewer's Signature: _____ Date: _____

Reason for Disaproval: _____

Please attest that the following information about the course you intend to conduct is true:

ALL AIDE COURSES

☐ yes 1. I have read and will follow the applicable regulations, curriculum guidelines and instructor manual in preparation for this course.

☐ yes 2. The primary text for this course will be the Kansas approved curriculum guidelines, if applicable. The 1999 Kansas approved curriculum guidelines will be used for all CNA courses. The 2003 approved curriculum will be used for all CMA courses. A secondary text is optional. If a student text or workbook is used, please note the author/s, title, edition and publisher here: _____

☐ yes 3. I will assure an adequate environment for the course, i.e., adequacy of classroom, availability of equipment, etc.

☐ yes 4. I will provide in writing to all students on the first day of class, the methods of student evaluation/grading including attendance requirements for classroom, clinical and makeup.

☐ yes 5. I will provide a program and instructor evaluation to the students which will be used to evaluate the success of this course.

☐ yes 6. During class or clinical instruction, the instructor will perform no other duties but the supervision of the trainees.

The person designated to assume the instructor's regular staff duties during this time is: _____.

☐ yes 7. I will inform both instructor and students of the state agency's phone number for registering complaints: (785) 296-6796.

☐ yes 8. I will notify KDHE prior to any changes or cancellations being made to the course.

☐ yes 9. I understand that additional information may be requested by the department to verify requirements have been met, and that the department may make unannounced onsite visits. I will keep a copy of the course schedule available at the training site.

☐ yes 10. I understand that this application must be received by Health Occupations Credentialing (HOC) at least three weeks (21 days) prior to the start date of the class. If a request for waiver is included, both must be received by HOC four weeks (28 days) before the course start date. All late applications will be returned.

☐ yes 11. I understand that no nurse aide who is employed by, or who has received an offer of employment from, a Medicare/Medicaid facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials). CFR 483.152(c)(1)

CNA COURSE AND 90-HOUR HHA COURSE:

☐ yes 1. The skills competency checklist will be completed at the conclusion of Part I. The original will be given to the student.

CMA COURSE, 20-HHA COURSE, and 90-HOUR HHA COURSE :

Which method of prescreening and testing will be utilized for students intending to take this course?

☐ CASAS ☐ Other (specify standardized test) _____

CMA CONTINUING EDUCATION COURSE ONLY:

☐ yes 1. The course will include a minimum of 10 hours of instruction in any or all of the following topics:

a. New classes of drugs and new drugs
b. New uses of drugs
c. New methods of administering drugs
d. Alternative treatments such as herbs, acupuncture, interaction with traditional drugs
e. Safety and administration of drugs
f. Documentation

CNA REFRESHER COURSE ONLY:

☐ yes 1. The course will include a minimum of five hours of didactic and five hours of lab or clinical experience.

☐ yes 2. The course will include didactic instruction on each of the following 9 topics and will also include lab or clinical instruction for items #4 through 9:

1. The nurse aide's responsibility in health care delivery
2. Communication
3. Resident's rights (including preventing and reporting ANE)
4. Safety, including the Heimlich maneuver
5. Infection control (including handwashing)
6. Bedmaking
7. Personal care skills (feeding, bathing, dressing, elimination needs, skin care)
8. Transfers, positioning and turning
9. Measurement and recording of vital signs

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided in this application and attachments.

Coordinator Signature

Instructor Signature

Please review the application verifying that the following items have been completed on the Application for Approval of Training Course. Return the check list along with the two pages of the application.

Page 1:

- ☐ Course type is checked.
- ☐ Course beginning and ending dates are provided. HOC will receive the application at least 3 weeks (21 days) prior to the start date; 4 weeks (28 days) if a request for waiver is included with the application.
- ☐ Sponsor, clinical and classroom information is provided with the sponsor's license/ID # and the clinical site's license #.
- ☐ Exam site preference is provided. KDHE will notify the instructor of site, date and time.
- ☐ Table of course hours is filled to meet the minimum requirements for the course:

  90-Hour CNA: at least 40 hours in part I and 50 hours in part II with a 50/50 ratio of class to clinical in part I and part II;

  90-Hour HHA: at least 40 hours in part I of which at least 28 hours are classroom instruction and 12 hours are clinical training and 50 hours in part II with at least 35 hours of classroom instruction and 15 hours of clinical training;

  75-Hour CMA: at least 75 hours of training with at least 25 hours of clinical training;

  20-Hour HHA: at least 20 hours of instruction, clinical training is optional;

  CMA Continuing Education: at least 10 hours of instruction in prescribed topics;

  OTA/PTA Bridge : at least 8 hours in part I of which at least 4 hours are classroom instruction and 4 hours are clinical training and 16 hours in part II with at least 8 hours of classroom instruction and 8 hours of clinical training;

  30-Hour Bridge : at least 15 hours of classroom instruction and 15 hours of clinical training;

  CNA Refresher Course : at least 5 hours of didactic and 5 hours of lab or clinical instruction.

Page 2 and 3:

- ☐ The specific course attestations have been provided.
- ☐ Coordinator has signed.
- ☐ Instructor has signed.

Page 4:

- ☐ Page 4 has been completed and will be returned along with the application.

Other:

- ☐ If time allows and there is a problem with this course application, please call, using phone numbers provided, the:
  ☐ Instructor ☐ Coordinator

  Please mail all correspondence to me and not to the sponsor listed on the front page:

Name _____ Organization _____

Address _____ City _____ State _____ Zip _____

Person Submitting This Application _____ Signature _____ Date _____

Return application including the checklist (4 pages required; 5th page is optional) with any necessary attachments to:

Health Occupations Credentialing
1000 SW Jackson, Suite 200
Topeka, KS 66612-1365

Phone number: (785) 296-6796
Fax number: (785) 296-3075
dstaab@kdhe.state.ks.us
Web site: www.kdhe.state.ks.us/hoc

Revised 8/2002 C:~^MyFiles~^ds~^AIDEcourses~^Forms~^CRSEAPPRV.2003.frm

ADDITIONAL INFORMATION

Is this course a Distance Learning Network, Interactive Network or similar type course? ☐ Yes ☐ No

Please list additional instructors, classroom and clinical sites here.

Instructor Name ______________________ Instructor's ID# ______________

KS RN License # ______________________ KS RN Licensure Expiration Date __________

Current Address: ____
Street City Zip

Current Phone # ______________ E-Mail Address: ______________________

Instructor Name ______________________ Instructor's ID# ______________

KS RN License # ______________________ KS RN Licensure Expiration Date __________

Current Address: ____
Street City Zip

Current Phone # ______________ E-Mail Address: ______________________

Instructor Name ______________________ Instructor's ID# ______________

KS RN License # ______________________ KS RN Licensure Expiration Date __________

Current Address: ____
Street City Zip

Current Phone # ______________ E-Mail Address: ______________________

Instructor Name ______________________ Instructor's ID# ______________

KS RN License # ______________________ KS RN Licensure Expiration Date __________

Current Address: ____
Street City Zip

Current Phone # ______________ E-Mail Address: ______________________

Classroom Site ______________________ KS Facility ID# ______________

Address ____
Street and/or PO Box City State Zip

Classroom Site ______________________ KS Facility ID# ______________

Address ____
Street and/or PO Box City State Zip

Classroom Site ______________________ KS Facility ID# ______________

Address ____
Street and/or PO Box City State Zip

Clinical Site ______________________ KS Facility ID# ______________

Address ____
Street and/or PO Box City State Zip

Clinical Site ______________________ KS Facility ID# ______________

Address ____
Street and/or PO Box City State Zip

Clinical Site ______________________ KS Facility ID# ______________

Address ____
Street and/or PO Box City State Zip